

CHANGE OF ADDRESS/CHANGE OF NAME FORM

To submit a change of address/change of name please fill out this form (typed or printed legibly).
When completed either fax to (916) 449-5654 or mail to:

California Department of Health Services
Drinking Water Program
Operator Certification Unit, MS 7417
P.O. Box 997413
Sacramento, CA 95899-7413

Operator's Name: _____
First Middle Initial Last

Water Distribution Operator No.: _____ Water Treatment Operator No.: _____

OLD MAILING ADDRESS

Mailing address (number, street)		City	State	Zip Code
Home telephone number	Work telephone number		E-mail address	

NEW MAILING ADDRESS

Mailing address (number, street)		City	State	Zip Code
Home telephone number	Work telephone number		E-mail address	

To request a name change, a copy of the legal document (naturalization papers, marriage license, etc.) changing the name must be submitted.

Former Name: _____
First Middle Initial Last

New Name: _____
First Middle Initial Last

I am hereby requesting a change of address/name change and certify that the above information is correct.

Original Signature

Date